Heart Failure Patient Record

| Date | Weight* | Blood Pressure | Pulse | Other |
|------|---------|-------------------|-------|-------|
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^{*}Use same scale/same amount of clothes/same time daily

Call your doctor or seek medical care if:

- 1) Weight increases by 2 pounds or more in a day;
- 2) Increased shortness of breath;
- 3) Tightness or pressure in chest;
- 4) Increased swelling in legs, ankles, hands or stomach.

Don't Smoke and Limit Alcohol.

Heart Failure Patient Record

| Name: | |
|--------|--|
| | |
| Phone: | |

| Date | Weight* | Blood Pressure | Pulse | Other |
|------|---------|-------------------|-------|-------|
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- 4) Increased swelling in legs, ankles, hands or stomach.

Don't Smoke and Limit Alcohol.

Developed by MDCH, CHV Section 4/06





| | I OF CO | RREN | T MED | ICATIO | ONS | |
|------------------------------------|---------|-----------|------------|-----------|-----------|-----------|
| Name | | Rea | Reason | | | e/Times |
| | | _ AC | ACE or ARB | | | |
| | | _ B-B | locker | | | |
| | | _ Diu | ıretic | Y/N | | |
| | | _ Dig | jitalis | Y/N | | |
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| Allergies: Advice: Diet: 2gm | | | | | | |
| Fluid Restrict | ion: 🔲 | yes _ | | _ oz./d | lay [| no |
| Flu Shot: | (data) | _ Pne | eumon | ia Shot | t: | (date) |
| Other: | | | | | (| (date) |
| Next Appt: | | | | | | |
| | (date) | (date) | (date) | (date) | (date) | (date) |
| | l | (initial) | (initial) | (:-:h:-1) | (initial) | /initial) |

| LIST | OF CURREN | IT MED | ICATIO | ONS | |
|--------------------------|---------------------|-----------|--------------|-----------|-----------|
| Name | Re | ason | | Dose | e/Times |
| | AC | E or AR | В | | |
| | B-I | Blocker | | | |
| | Di | uretic | Y/N | | |
| | Dic | gitalis | Y/N | | |
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| Allergies: | | | | | |
| Advice: Diet: 🔲 2gm s | odium/day | Otho | <i>.</i> . □ | | |
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| Fluid Restriction | <u> </u> | | | | _ |
| Flu Shot: | Pn late) | eumoni | a Shot | : | date) |
| Other: | | | | | |
| Next Appt: | | | | | |
| ' | (date) (date) | (date) | (date) | (date) | (date) |
| | (initial) (initial) | (initial) | (initial) | (initial) | (initial) |
| _ | | | | | |

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|-------------------|
| Phone: |
| Physician: |
| Phone: |
| Home Care Agency: |
| Nurse: |
| Phone: |

| Physician: |
|-------------------|
| Phone: |
| Physician: |
| Phone: |
| Home Care Agency: |
| Nurse: |

Phone: